

## **Choice Value Plan**

With this HSA Choice high-deductible health plan coverage, you have the option to open a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service. The account acts like a regular checking account with a debit card and accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable among employers. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

HSA Choice plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms.

### ***Some of the Important Benefits of Your Plan:***

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination<sup>SM</sup> services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

# Choice Value Plan

Types of Coverage

Network Benefits

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description available on the worksource services portal.**

If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.

\*Prior Notification is required for certain services. Failure to obtain prior notification may result in a reduced benefit

**Combined Medical and Drug Annual Deductible:** For single coverage, the Annual Deductible is \$1,500 per Covered Person per calendar year. For family coverage, the Annual Deductible is \$3,000 per calendar year for all Covered Persons in a family. **No one in the family is eligible for benefits until the family deductible is satisfied.**

**Combined Medical and Drug Out-of-Pocket Maximum:** For single coverage, the Out-of-Pocket Maximum is \$5,000 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is \$10,000 per calendar year for all Covered Persons in a family. **The Out-of-Pocket Maximum does include the Annual Deductible.**

**Maximum Policy Benefit** No Maximum Policy Benefit.

<b>1. Ambulance Services - Emergency only</b>	Ground Transportation: 10% of Eligible Expenses after Deductible met. Air Transportation: 10% of Eligible Expenses after deductible met.
<b>2. Dental Services - Accident only</b>	*10% of Eligible Expenses after deductible met. *Prior notification is required before follow-up treatment begins.
<b>3. Durable Medical Equipment</b> Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.  <b>Hearing Aids are limited to one every 3 years and a separate \$2,500 per calendar year maximum</b>	10% of Eligible Expenses after deductible met.
<b>4. Emergency Health Services</b>	10% of Eligible Expenses after deductible met.
<b>5. Eye Examinations</b> Refractive eye examinations are limited to one every other calendar year from a Network Provider.	10% of Eligible Expenses after deductible met.
<b>6. Home Health Care</b> Benefits are limited to 60 visits for skilled care services per calendar year.	10% of Eligible Expenses after deductible met.
<b>7. Hospice Care</b>	10% of Eligible Expenses after deductible met.
<b>8. Hospital - Inpatient Stay</b>	10% of Eligible Expenses after deductible met.
<b>9. Injections Received in a Physician's Office</b>	10% per injection after deductible met.
<b>10. Maternity Services</b>	Same as 8, 11, 12 and 13
<b>11. Outpatient Surgery, Diagnostic and Therapeutic Services</b>	
Outpatient Surgery	10% of Eligible Expenses after deductible met.
Outpatient Diagnostic Services	For preventive diagnostic services 100% - Deductible does not apply For preventive mammography testing, 100% - Deductible does not apply. For sickness and injury related diagnostic services – 10% of eligible expenses after deductible met.
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses after Deductible met.
Outpatient Therapeutic Treatments	10% of Eligible Expenses after Deductible met.
<b>12. Physician's Office Services</b>	Preventive medical care: 100% - Deductible does not apply. Sickness & Injury: 10% of Eligible Expenses after deductible met.
<b>13. Professional Fees for Surgical and Medical Services</b>	10% of Eligible Expenses after deductible met.
<b>14. Prosthetic Devices</b> Benefits for prosthetic devices are limited to \$2,500 per calendar year.	10% of Eligible Expenses after deductible met.
<b>15. Reconstructive Procedures</b>	Same as 8, 11, 12, 13 and 14

## Types of Coverage

## Network Benefits

**16. Rehabilitation Services - Outpatient Therapy**

Benefits are limited as follows: 60 visits of physical therapy; 60 visits of occupational therapy; 60 visits of speech therapy; 60 visits of pulmonary rehabilitation; and 60 visits of cardiac rehabilitation per calendar year.

10 % of Eligible Expenses after deductible met.

**17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Benefits are limited to 60 days per calendar year.

10% of Eligible Expenses after deductible met.

**18. Transplantation Services**

\*10% of Eligible Expenses after deductible met.

**19. Urgent Care Center Services**

10% of Eligible Expenses after deductible met.

## Additional Benefits

**Mental Health and Substance Abuse Services - Outpatient**

Must receive prior authorization through the Mental Health/Substance Abuse Designee

10% of Eligible Expenses after deductible met.

**Mental Health and Substance Abuse Services - Inpatient and Intermediate**

Must receive prior authorization through the Mental Health/Substance Abuse Designee

10% of Eligible Expenses after deductible met.

**Spinal Treatment**

Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to 20 visits per calendar year.

10% of Eligible Expenses after deductible met.

**Reproduction**

Benefits include Voluntary sterilization, Health services and associated expenses for therapeutic abortion, Contraceptive supplies and services. Fetal reduction surgery,

Same as 8, 11, 12 and 13.

**Temporomandibular Joint Syndrome (TMJ)**

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

10% of Eligible Expenses after deductible met

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Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

#### A. Alternative Treatments

Acupressure; hypnosis; reiki; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

#### B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

#### C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or supernumerary teeth is excluded, even if part of a Congenital Anomaly.

#### D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

#### E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

#### F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

#### G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

#### H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

#### I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. Exception Enteral formulas necessary for the treatment of Phenylketonuria (PKU) or other heritable diseases

#### J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant

followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs unless as a result of chemotherapy..

#### K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

#### L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization. Elective abortions.

#### M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

#### N. Transplants

Health services for organ or tissue transplants, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

#### O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

#### P. Vision

Purchase cost of eye glasses or contact lenses. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

#### Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity ( except for morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.

## Choice Value Plan *Pharmacy*

The pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications

While most pharmacies participate in the network, you should check first. Call your pharmacist or visit the online pharmacy service at [www.myuhc.com](http://www.myuhc.com). The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

**Under this pharmacy coverage plan, a deductible and out-of-pocket maximum apply. Please refer to the medical plan documents for the annual deductible & out-of-pocket maximum amounts. The deductible and the out-of-pocket maximum include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the copayments listed below. If you reach the out-of-pocket maximum, you will not be required to pay a copayment.**

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### Coinsurance per Prescription Order or Refill

Note that some Prescription Drug Products require that you notify the Claims Administrator's designee in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

#### Retail Network Pharmacy

For up to a 31 day supply

10%

#### Home Delivery Network Pharmacy

For up to a 90 day supply

10%

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Specialty medications are typically more than \$250 per prescription, in an injectable or oral form, treat rare or complex diseases and typically require additional clinical support for better health outcomes.

**Starting on January 1, 2010, you will need to use Prescription Solutions, UnitedHealthcare's new in-network specialty pharmacy provider, to receive in-network coverage for your specialty medication.** You can continue to fill your *non-specialty* prescriptions at your regular retail or mail order pharmacy.

- ◆ Call Prescription Solutions as soon as possible at 1-888-739-5820 and one of their staff will obtain your information, ID number, and doctor's information and then contact your doctor to get a new prescription for your specialty medication.
- ◆ Prescription Solutions can help answer any questions you have and will begin the process of working with you and your health care provider to fill your specialty medication.
- ◆ Prescription Solutions will also work with you to schedule your delivery or even arrange for emergency delivery, if necessary.

**For more information about our program or to get started ordering your specialty medication(s), please contact Prescription Solutions at 1-888-739-5820.** Representatives are available 5:00 a.m. to 7:00 p.m. Pacific Time, Monday through Friday. On-call pharmacists are available 24 hours a day, seven days a week for emergency situations.

# Choice Value Plan

## Other Important Cost Sharing Information

**NOTE:** If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

### Annual Drug Deductible

See Medical Benefit Summary – annual deductible combined with medical plan.

### Out-of-Pocket Drug Maximum

See Medical Benefit Summary – annual out-of-pocket combined with medical plan.

## Exclusions

*Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:*

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This

exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed

Prescription Drug Product that was lost, stolen, broken or destroyed.

Prescription Drug Products when prescribed to treat infertility.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug.

Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by the Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

This Summary Plan Description is intended only to highlight your Benefits for outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all your outpatient prescription drug expenses. Please refer to your Outpatient Prescription Drug Rider and the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Summary Plan Description, the Outpatient Prescription Drug Rider and Summary Plan Description prevail. Capitalized terms in the Benefit Summary are defined in the Outpatient Prescription Drug Rider and/or Summary Plan Description.

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